CONFIDENTIAL PATIENT INFORMATION

DATE ___/___/___

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME Bob Jones DATE OF BIRTH 10/5/52 AGE ___ Male ☒ Female ☐

ADDRESS 123 Main Street APT#_____ SSN 555-55-5555

CITY Atlanta STATE GA ZIP CODE 30022 HOME PHONE (770) 814-2442

ALTERNATE PHONE (CELL): (_____)_____ EMAIL ADDRESS: _____

EMPLOYER'S NAME ABC Company OCCUPATION Salesman

WORK ADDRESS 234 State Street CITY Atlanta STATE GA ZIP 30022

WORK PH. # (770) 555-5522 EXT._____ DATE SYMPTOMS BEGAN: ___/___/___

MARITAL STATUS: SINGLE ☐ MARRIED ☒ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____ PHONE_____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐

TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐

I WILL BE PAYING TODAY BY CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☒ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____

INSURED'S EMPLOYER SAME AS ABOVE ☒ _____

INSURED'S SSN SAME AS ABOVE ☒ SSN ___-___-___ INSURED'S DOB SAME AS ABOVE ☐ ___/___/___

PRIMARY INSURANCE CO. All Cities ADDRESS 400 State Street

CITY Atlanta STATE GA ZIP CODE 30022 PHONE#(____)_____

POLICY NUMBER 840 GROUP NUMBER 2255

****

SECONDARY INSURANCE CO._____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(____)_____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

VERIFICATION OF INSURANCE BENEFITS

IF GROUP INSURANCE: Is there coverage for Chiropractic Care? **YES** ☐ **NO** ☐ **DATE** ___/___/____

Plan Administered by _____ Is Doctor **In Network** ☐ **Out of Network** ☐

Pre-Authorization Required? ? **YES** ☐ **NO** ☐

IN NETWORK BENEFITS

Amount of Deductible:$_____/Individual $_____/Family

Deductible met? **YES** ☐ **NO** ☐ $_____ Remaining

Deductible **Calendar** ☐ or **Fiscal** ☐ Renewal Date ___/___/___

Max. Yearly Benefit ? $ _____ Co-pay $_____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? **YES** ☐ **NO** ☐ $_____

Exclusions/Limitations: _____

OUT OF NETWORK BENEFITS

Amount of Deductible:$_____/Individual $_____/Family

Deductible met? **YES** ☐ **NO** ☐ $_____ Remaining

Deductible **Calendar**☐ or **Fiscal** ☐ Renewal Date___/___/____

Max. Yearly Benefit ? $ _____ Co-pay $_____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? **YES** ☐ **NO** ☐ $_____

Exclusions/Limitations: _____

Notes: _____

Spoke to Whom?_____ Mail Claims to: _____

Direct Telephone: _____ Address: _____

City _____ State _____ Zip _____

IF AUTO ACCIDENT

Who was found at fault / ticketed **Patient** ☐ **Other Driver** ☐

Insured Auto Insurance Carrier._____ Address _____

City _____ State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified?_____

Deductible Amount? $_____ Spoke to Whom?_____

Does your auto insurance coverage have **Medical Payments** Coverage? **YES** ☐ **NO** ☐

If yes, Auto Insurance Carrier._____ Address _____

City _____ State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified?_____

Deductible Amount? $_____ Spoke to Whom?_____

ATTORNEY'S NAME _____ PHONE#(_____)_____

IF WORKER'S COMPENSATION:

Employer's Name_____ Employer's #(_____)_____

Employer's Address:_____ Is patient Currently Employed at Same? _____

Has the injury been reported? **YES** ☐ **NO** ☐ Has care been authorized? ? **YES** ☐ **NO** ☐ By whom? _____

Employer's Insurance Carrier._____ Address _____

City _____State _____ ZIP Code _____ Phone#(_____)_____

POLICY NUMBER _____ GROUP NUMBER _____

HEALTH QUESTIONNAIRE

● Initial ○ Re-Eval

Patient Name: _____

MO	DAY	YEAR	DR#	PATIENT NUMBER

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭ **Erase** changes cleanly. Do **not fold** form.

A. PATIENT INFORMATION

Marital Status:
○ Single
● Married
○ Separated
○ Divorced
○ Widowed

Sex:
● M ○ F

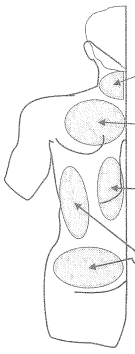
Children:
○ ● ○ ○ ○ ○

Patient Lives With:
○ Alone ○ Parents
● Spouse ○ Roomate(s)
● Children ○ Assisted Living
○ Other

B. PATIENT'S COMPLAINTS

1. Mark Your Present Complaints Below ○ Physical Examination with no complaints

Neck / Back

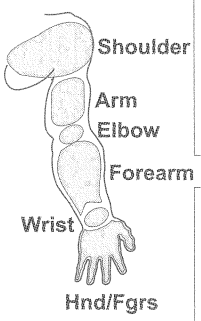


		Same As Left	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	Left		●	●	●	●	S	S	W	M	●	S	B	●	S	S	A	T	O	I	●	C	I	W	●	R
	Right	●	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Upr Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Mid Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Low Back	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Ribs	Left		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Neck/Back Complaints Begin?

● Date: 8 / 1 / 16

Upper Extremities



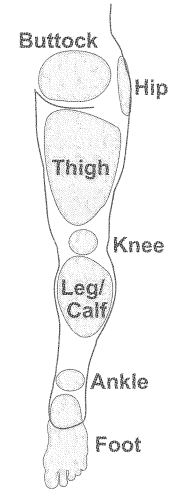
		Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Shoulder		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Shoulder		P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Upper Extremity Complaints Begin?

○ Same Date As Neck/Back

○ Different Date: / /

Lower Extremities



		Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Hip	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Foot	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Hip	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Foot	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Lower Extremity Complaints Begin?

○ Same Date As Neck/Back

○ Different Date: / /

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647613

PLEASE MAKE NO MARKS IN THIS AREA

B. PATIENT'S COMPLAINTS (CONTINUED)

2. How Did Your Complaint(s) Begin[1]?
○ Unknown ○ Suddenly ● Gradually

3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?
● Cause Not Known ○ Auto Accident
○ Work Accident/Injury ○ Home Accident
○ Personal Injury ○ Sport Injury
○ Other - Describe: _____

4. How Would You Rate Your Overall Pain Today Where 0 Is No Pain And 10 Is The Worst Pain[1]?
No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ● 6 ○ 7 ○ 8 ○ 9 ○ 10 Worst Pain Possible

5. When Are Your Symptoms Worse?
○ Morning ○ Afternoon ○ Evening ○ Night
● Always The Same

6. What Makes Your Condition Better?
○ Nothing ○ Stretching ○ Heat
● Rest ○ Exercise ● Ice
○ Sitting ○ Standing ○ Medications
○ Other _____

7. What Makes Your Condition Worse?
○ Nothing ○ Coughing ○ Reaching ○ Standing
○ Sneezing ○ Lifting ○ Sitting ○ Pulling
● Bending ○ Walking ○ Straining at Stool ● Turning
○ Other _____

8. Have Any Of Your Complaint(s) Existed In The Past? ○ Yes ● No
If Yes, Indicate Below
○ Neck ○ Upr Back ○ Mid Back ○ Low Back ○ Ribs
○ Shoulder ○ Arm ○ Elbow ○ Forearm ○ Wrist ○ Hnd/fgr
○ Buttock ○ Hip ○ Thigh ○ Knee ○ Leg/calf ○ Ankle
○ Foot ○ Others: _____

9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office[1]?
○ Yes ● No If Yes, List Dates, Treatments, And Doctors.

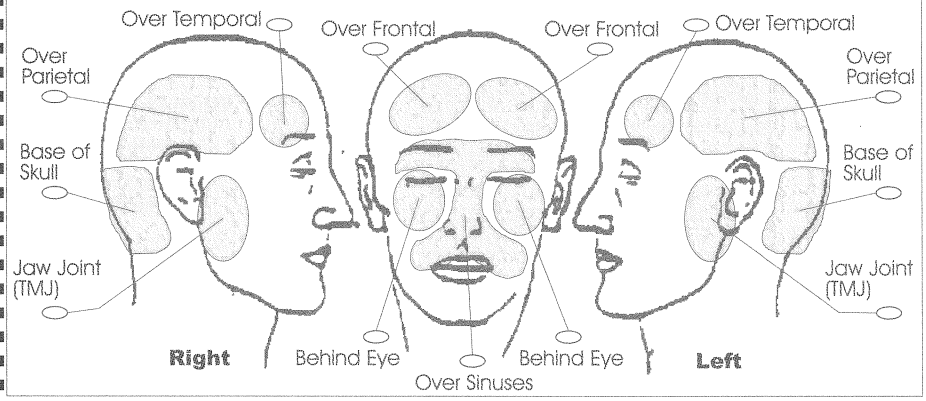
10. Since Your Symptoms Began, Have You Noticed A Change In?

Bowel Function	○ Yes	○ No	● No To All
Bladder Function	○ Yes	○ No	
Sexual Function	○ Yes	○ No	

C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

1. Where is The Pain Associated With Your Headaches Located?



2. On What Date Did Your Headaches Begin[1]?
○ Date: __/__/__ ○ Same As Neck/Back Complaints

3. How Does The Intensity Of Your Headaches Rate[1]?
No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Worst Pain Possible

4. What Describes Your Pain?
○ Dull ○ Sharp ○ Aching ○ Stabbing
○ Deep ○ Vice-Like ○ Burning ○ Throbbing/Pulsating
○ Other _____

5. When Do Your Headaches Usually Start?
○ Constant/Anytime Awake ○ Wake Up With In Morning
○ At Midday ○ During Evening

6. What Seems To Bring On Your Headaches?
○ Physical Activity ○ Caffeine
○ Excessive Stress ○ Certain Foods
○ Alcohol ○ Menstrual Period
○ Other _____

7. How Often Do They Occur[1]?
Times/Week: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
Times/Month: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
○ Other _____

8. How Long Do Your Headaches Last[1]?
○ Less Than 1 Hour ○ From 1-3 Hours
○ Longer Than 3 Hours ○ All Waking Hours
○ Several Hours To Days
○ Other _____

9. Do Your Headaches Wake You From Sleep[1]?
○ No ○ Sometimes ○ Always

10. Do Any Of The Following Occur With Your Headaches?
○ Nausea/Vomiting ○ Weakness
○ Tremor ○ Vision Problems
○ Dizziness ○ Light/Sound Sensitivity
○ Other _____

11. What Makes Your Headaches Better?
○ Nothing ○ Rest ○ Lying Down ○ Ice/Cold Packs
○ Massage ○ Standing ○ NSAIDS (Aspirin, Tylenol, etc.)
○ Other _____

D. OTHER COMPLAINTS

Do you have any other complaints not covered on this form[1]? ○ Yes ● No

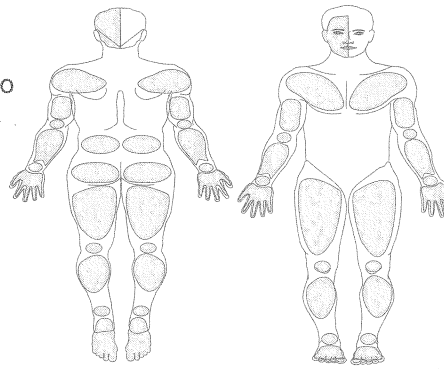
If Yes, Describe other complaints in detail and mark body areas on Figures. →

_____

_____

_____

_____



HEALTH QUESTIONNAIRE-HISTORY

Patient's Name

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

○ None Of The Symptoms Listed Below	○ No New Symptoms Since Your Last Exam

- ● General Fatigue
- ○ Weakness
- ○ Fever (continuous)
- ○ Loss Of Sleep
- ○ Chills (continuous)
- ○ Weight Change (unplanned)
- ○ Night Sweats

- ○ Headaches
- ● Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Nervousness

- ○ Anxiety
- ○ Depression (prolonged)
- ○ Phobias (excessive fears)
- ○ Memory Loss Or Impairment
- ○ Mood Swings (excessive)

	Left	Right
Hearing Trouble	○	○
Ringing in Ears	○	○
Pain in Ears	○	○
Ear Discharge	○	○
Vision Trouble	○	○
Pain in Eyes	○	○
Eye Discharge	○	○

- ○ Nose/Sinus Pain
- ○ Excessive Drainage
- ○ Nose Bleeds (chronic)
- ○ Nasal Infections (chronic)
- ○ Absence Of Smell

- ○ Mouth Sores
- ○ Bleeding Gums
- ○ Enlarged Glands
- ○ Absence Of Taste
- ○ Abnormal Taste Sensation
- ○ Tonsillitis/Infected Tonsils
- ○ Difficulty With Swallowing

- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter (enlargedThyroid gland)
- ○ Tremor (shaking)

- ○ Skin Rash
- ○ Redness Of Skin
- ○ Skin Itching
- ○ Skin Dryness
- ○ Eczema(red, inflamed skin)
- ○ Hair Changes (unplanned)
- ○ Nail Changes (unplanned)
- ○ Bruise Easily

- ○ Cough (chronic)
- ○ Wheezing (chronic)
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Varicosities (visible veins)
- ○ Rapid Heart Beat
- ○ Chest Pain
- ○ Heart Palpitations
- ○ Heart Murmur

- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Hemorrhoids
- ○ Excess Gas
- ○ Vomiting (excessive)
- ○ Diarrhea (excessive)
- ○ Constipation (excessive)
- ○ Heartburn/Indigestion

- ○ Painful Urination
- ○ Inability To Hold Urine
- ○ Frequent Urination
- ○ Urinary Retention
- ○ Bed-wetting
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Sterility
- ○ Impotence

- ○ Lumps In Breast(s)
- ○ Redness/Itching of Breast
- ○ Dimpling of Breast(s)
- ○ Discharge from Breast(s)
- ○ Breast Pain

○ Other (Please Describe)

F. HABITS/ACTIVITIES

What Are Your Current Habits?

	Never	<1 Packs Per Day	1-2	2-3	3-4	5+
Smoking	●	○	○	○	○	○

	Never	<1 Glasses Per Day	1-2	2-3	3-4	5+
Caffeinated Drinks	○	●	○	○	○	○
Alcohol Consumption	○	●	○	○	○	○

	No	Yes	If Yes, Discuss With Doctor
Drug/Substance Abuse	●	○	

	Never	<1 Days Per Week	1-2	2-3	3-4	5+
Exercise	○	○	○	○	●	○

Kinds Of Exercise You Do:

- ○ Walking ○ Jogging ○ Cycling ○ Swimming
- ● Golf ○ Tennis ● Strength Training
- ○ Other: _____

G. MEDICAL HISTORY

1.HEALTH CARE

a. Have You Ever Been To A Chiropractor? Yes ○ No ●

b. Do You Have A Family Physician Yes ● No ○

Date Of Last Physical Exam: 12-1-15

Physician's Name: Ben Casey MD

Address: 567 North Ave Atlanta, GA 30022 Phone: (770)399-1000

c. Have You Been Hospitalized In The Past? Yes ○ No ●

Date & Reason For Hospitalization: _____

d. Have You Ever Had Surgery? Yes ○ No ●

Date, Reason, Results Of Surgery: _____

e. Have You Ever Had A Serious Accident/Injury? Yes ○ No ●

List Date & Describe Injury:

- ○ Auto: _____
- ○ Work-Related: _____
- ○ Personal: _____
- ○ Sports Injury: _____
- ○ Other: _____

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) Yes ● No ○

multivitamins

g. Are You Currently Taking Any Medications? Yes ● No ○

For What Condition(s) Are You Taking Medication?

- ● Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.): Motrin 800 neck/back pain
- ○ Pain/Analgesics: _____
- ○ Anti-Depressants: _____
- ○ Muscle Relaxants: _____
- ○ Blood Pressure Pills: _____
- ○ Antibiotics: _____
- ○ Birth Control Pills: _____
- ○ Corticosteroid: _____
- ○ Other: _____

In The Past Have You Use Any Of The Following?

○ Birth Control Pills ○ Corticosteroid

h. Are You Allergic To Any Medications? Yes ● No ○

List Medications: penicillin

G. MEDICAL HISTORY - CONTINUED

1i. WOMEN ONLY:

	Yes	No
To Your Knowledge, Are You Pregnant?	○	○
If Pregnant In Past, Were Pregnancies Normal?	○	○
Are You Seeing An OB-GYN Regularly?	○	○

Number Of Births: ① ② ③ ④ ⑤ ○ Other:___

Date Of Last Exam:_____

Physician's Name:_____

Address:_____

_____ Phone:( )_____

2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased?
Father	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Mother	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	D
Brothers	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Sisters	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	
Children	C	D	H	H	S	K	A	M	H	O	A	J	S	P	D	C	G	O	

Describe Others:_____

3. Conditions Or Illnesses

Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:

○ ***No Current Or Previous Conditions/Illnesses***

Now Have	In Past		Now Have	In Past	
H	P	Sinus Trouble	H	P	Kidney Trouble
H	P	Hay Fever	H	P	Urinary Retention
●	P	Allergies	H	P	Frequent Urination
H	P	Asthma	H	P	Prostate Trouble
H	P	Emphysema	H	P	Arthritis
H	P	Tuberculosis	H	P	Osteoporosis
H	P	History of Infection	H	P	Scoliosis
H	P	Fever (Continuous)	H	P	Dislocated Joints
H	P	Cancer/Tumor	H	P	Spinal Disc Disease
H	P	Diabetes	H	P	Bone Fracture (list/dates):
H	P	Visual Disturbances			
H	P	Dizziness/Fainting			
H	P	Epilepsy/Seizures			
H	P	Thyroid Trouble	H	P	Mental/Emotional Difficulty
●	P	High Blood Pressure	H	P	Sex. Trans. Diseases
H	P	Low Blood Pressure	H	P	HIV
H	P	Heart Trouble	H	P	AIDS/ARC
H	P	Pacemaker	H	P	Abnormal Weight Gain
H	P	Stroke [date_____]	H	P	Abnormal Weight Loss
H	P	Aortic Aneurysm	H	P	Numbness Groin/Buttocks
H	P	Anemia	H		Other:
H	P	Rheumatic Fever			
H	P	Polio			
H	P	Multiple Sclerosis		P	Other:
H	P	Ulcer			
H	P	Liver Trouble			

H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Are You Right Or Left Handed? ● Right ○ Left

2. Job Type

○ Retired ○ Unemployed ○ Full-Time Student

If Any Of Above Skip Rest, Sign At Patient's Signature

● Full Time ○ Part Time ○ Temporary

○ Self-Employed ○ Other

3. During Your Work Week, You Work How Many:

Hours Per Day ① ② ③ ④ ⑤ ⑥ ⑦ ● ⑨ ⑩ ⑪ ⑫

Days Per Week ① ② ③ ④ ● ⑥ ⑦

○ Other

4. How Long Have You Been With Your Present Employer

Years ● ⑳ ㉚ ㊵ ㊿ ① ② ③ ④ ⑤ ● ⑦ ⑧ ⑨

Months ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪

5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day? ● Yes ○ No

6. What Is Your Primary Work Position and Location?

a. Work Position: ● Seated ○ Standing ○ Other

b. Work Location: ● Desk ○ Counter ○ Workbench ○ Other

7. What Movements Does Your Job Require?

● Bending ● Turning ● Stooping

● Twisting ○ Walking ○ Repetitive Hand Use

○ Carrying ○ Other

8. Does Your Work Include Any Of The Following Use?

● Prolonged Computer ● Continuous Phone

9. Does Your Job Involve Lifting?

○ Never ● Occasionally ○ Intermittently

○ Frequently ○ Constantly

How Many Pounds? (Choose Only One) ○ 10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90 ○ 100+ Pounds

10. What Best Describes Your Stress Level At Work?

○ None ○ Minimal ● Minimal To Moderate

○ Moderate ○ Moderate To Extreme ○ Extreme

11. How Do You Rate Your Physical Activity At Work?

● Seated more than 50% of workday

Manual Labor: ○ Light ○ Light To Moderate ○ Moderate ○ Moderate To Heavy ○ Heavy

12. Do Work Activities Aggravate Your Present Complaints?

○ Yes ● No **If Yes, Explain:**_____

PATIENT'S SIGNATURE **DATE:**

SCANTRON EW-239487-2:23

647613

PLEASE MAKE NO MARKS IN THIS AREA

CLINICAL EVALUATION

● Clinical Evaluation ○ Clinical Re-Evaluation Case: ① ② ③ ④ ⑤

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER
① ⑦	①	0	0 0 0	0 0 0 0 0 0 0 0 0 0
② ⑧	②	10 1	1 1 ●	1 1 1 1 1 1 1 1 1 1
③ ⑨	③	20 2	2 2 2	2 2 2 2 2 2 2 2 2 2
④ ⑩	④	30 3	3 3 3	3 3 3 3 3 3 3 3 3 3
⑤ ⑪	⑤	40 4	4 4 4	4 4 4 4 4 4 4 4 4 4
⑥ ⑫	⑥	50 5	5 5 5	5 5 5 5 5 5 5 5 5 5
	⑦	60 6	6 6 6	6 6 6 6 6 6 6 6 6 6
	⑧	70 7	7 7 7	7 7 7 7 7 7 7 7 7 7
	⑨	80 8	8 8 8	8 8 8 8 8 8 8 8 8 8
		90 9	9 9 9	9 9 9 9 9 9 9 ● ● ● ● ●

A. PHYSICAL EXAMINATION

1. DEMEANOR

○ Coherent ○ Relaxed ○ Nervous ○ Agitated ○ Disinterested
○ Incoherent ○ Alert Distressed: ○ Mild ○ Moderate ○ Severe
○ Other _____

○ All VITALS STABLE

2. HEIGHT

Feet ① ② ③ ④ ⑤ ⑥ ⑦ Inches ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪

3. WEIGHT

Hund	100 200 300 400
Tens	10 20 30 40 50 60 70 80 90
Units	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

4. TEMPERATURE

Hund	100
Tens	70 80 90
Units	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
Pnts.	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

5. PULSE ● Regular ○ Dysrhythmic

Hund	100 200
Tens	10 20 30 40 50 60 ● 80 90
Units	① ● ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

6. RESPIRATION RATE

Tens	10 20 30 40 50 60 70 80 90
Units	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

7. BLOOD PRESSURE

● Seated ○ Standing ○ Supine

Systolic - Left		Systolic - Right	
Hund	● 200	Hund	● 200
Tens	10 20 30 40 50 ● 70 80 90	Tens	10 20 30 40 50 ● 70 80 90
Units	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
Diastolic - Left		**Diastolic - Right**	
Hund	100	Hund	100
Tens	10 20 30 40 50 60 70 80 ●	Tens	10 20 30 40 50 60 70 80 ●
Units	① ● ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units	① ● ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

8. HEAD/FACIAL MUSCLES

○ Muscles Intact. No Masses, Tenderness, Lacerations, or Abrasions Apparent.
○ Abnormality

9. EYES

Pupils Round, Regular and Equal. Normal Reaction to Light and Accommodation.
○ Extraocular Movements Full In All Fields of Gaze. No Nystagmus Apparent.
○ Abnormality

10. EARS

External Auditory Meatus and Auditory Canal Normal in Appearance, Color, and W/O
○ Foreign Bodies. Tympanic Membrane and Auditory Perceptions WNL.
○ Abnormality

11. NOSE/THROAT

External Symmetry, Septum, Sinuses and Mucosa WNL. No Apparent Pathologies.
○ No Observed Pathologies of Lips, Gums, Tongue, Tonsils, Mucosa or Pharynx.
○ Abnormality

12. THORAX

○ WNL for Size, Shape, and Symmetry. Diaphragmatic Excursions WNL.
○ Abnormality

13. LUNG FIELDS

● Clear to Auscultation and Percussion
○ Abnormality

14. CARDIAC AUSCULTATION

● No Apparent Murmurs, Splitting, or Abnormal Heart Sounds
○ Abnormality

15. ABDOMEN

● No Masses, Tenderness, Rigidity, or Apparent Bruits
○ Abnormality

16. LYMPH NODES

● WNL for Size, Consistency, Mobility, and Condition
○ Abnormality

17. PERIPHERAL CIRCULATION (2=Normal)

a. Arterial Pulses

		0	1	2	3	4
Brachial	Left	0	1	2	3	4
	Right	0	1	2	3	4
Radial	Left	0	1	2	3	4
	Right	0	1	2	3	4
Femoral	Left	0	●	2	3	4
	Right	0	●	2	3	4
Popliteal	Left	0	1	2	3	4
	Right	0	1	2	3	4
Posterior Tibial	Left	0	●	2	3	4
	Right	0	●	2	3	4
Dorsalis Pedis	Left	0	●	2	3	4
	Right	0	●	2	3	4

b. Lower Extremity Venous

	WNL	Enlarged	Tender	Increased Temp	Varicosity	Homan's Sign	Other
Left	W	E	T	I	V	H	O
Right	W	E	T	I	V	H	O

Other: _____

18. OF ADDITIONAL NOTE

A B C D E F G H I

19. MEDICAL RECORDS

A B C D E F G H I

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PLEASE MAKE NO MARKS IN THIS AREA

B. POSTURE EXAMINATION

1. OBSERVATIONS

a. Body Type:

○ Ectomorph (Lean/Skinny) ○ Endomorph (Large Abdomen/ Rounded-Average) ○ Mesomorph (Muscular/ Robust) ○ Obese

b. Presentation:

○ Erect

Cervical	Torticollis:	○ Left ○ Right ○ Slight ○ Moderate ○ Severe
	Antalgic:	○ Left ○ Right ○ Flexion Antalgia ○ Slight ○ Moderate ○ Severe
Torso/ Lumbar	Antalgic:	○ Left ○ Right ○ Flexion Antalgia ○ Slight ○ Moderate ○ Severe

c. Ambulation:

○ Normal Difficulty: ○ Slight ○ Moderate ○ Severe
○ With Assistance ○ Non-Ambulatory

d. General

	Left	Right
Head Tilt	L	R
High Ear	L	R
High Shoulder	L	R
High Illium	L	R
Winged Scapula	L	R

e. Cervical

	Left	Right	Anterior	Posterior
Translation	L	R	A	P
Lateral Flexion	L	R		
Rotation	L	R		
Flexion	F			
Extension	E			

f. Torso

	Left	Right	Anterior	Posterior
Translation	L	R	A	P
Lateral Flexion	L	R		
Rotation	L	R		
Flexion	F			
Extension	E			

g. Pelvis

	Left	Right	Anterior	Posterior
Translation	L	R	A	P
Rotation	L	R		
Flexion	F			
Extension	E			

h. Feet

	Pronation			Supination	Foot	
	Hyper	Hypo	Pes Planus	(high arch)	Inversion	Eversion
Left	HR	HO	P	S	I	E
Right	HR	HO	P	S	I	E

2. LEG LENGTH DEFICIENCY

○ Legs Balanced

	Left	Right	1/8	1/4	3/8	1/2	5/8	3/4	7/8	1	1 1/4	1 1/2	1 3/4	2
Supine	L	R	1/8	1/4	3/8	1/2	5/8	3/4	7/8	1	1 1/4	1 1/2	1 3/4	2
Prone	L	R	1/8	1/4	3/8	1/2	5/8	3/4	7/8	1	1 1/4	1 1/2	1 3/4	2
Anatomical	L	R	1/8	1/4	3/8	1/2	5/8	3/4	7/8	1	1 1/4	1 1/2	1 3/4	2
Other 1	L	R	1/8	1/4	3/8	1/2	5/8	3/4	7/8	1	1 1/4	1 1/2	1 3/4	2
Other 2	L	R	1/8	1/4	3/8	1/2	5/8	3/4	7/8	1	1 1/4	1 1/2	1 3/4	2
Cervical Dependent	S	P	O1	O2										
Pelvic Dependent	S	P	O1	O2										

3. ORTHOPEDIC TESTS

	(-)	(+)	Functional Scoliosis	Structural Scoliosis	Sciatica
a. Adam's Sign	−	+	F	S	L R

b. Minor's Sign

(-)	(+) Pain		
−	+	++	+++

4. OF ADDITIONAL NOTE

A B C D E F G H I J K L

C. NEUROLOGICAL ASSESSMENT

1. CEREBROVASCULAR FUNCTION

a. Carotid Pulsations

	0	1	2	3	4
Left	0	1	●	3	4
Right	0	1	●	3	4

b. Bruits

		Absent	Present
Carotid	Left	●	P
	Right	●	P
Subclavian	Left	●	P
	Right	●	P

c. Craniocervical Functional Maneuver

	Negative	Positive	Findings
Left	●	+	F
Right	●	+	F

2. CRANIAL NERVES

● Cranial Nerves I-XII Intact / Except:

Nerve		Abnormal	Nerve		Abnormal	Nerve		Abnormal
CNI	Olfac	○	CNV	Trigem	○	CNIX	Glosso	○
CNII	Optic	○	CNVI	Abduc	○	CNX	Vagus	○
CNIII	Oculo	○	CNVII	Facial	○	CNXI	Sp.Acc	○
CNIV	Troch	○	CNVIII	Vst-Ac	○	CNXII	Hypogl	○

Findings:

1	2	3
4	5	6
7	8	9
10	11	12

3. CEREBELLAR FUNCTION

a. Gait ● Normal

○ Spastic Hemiparesis ○ Spastic Diplegia
○ Steppage ○ Cerebellar Ataxia ○ Sensory Ataxia

b. Rapidly Alternating Movements

	Quickly and Accurately	Moderate Incoordination	Clumsily	Unable to Perform
Left	●	MI	C	UP
Right	●	MI	C	UP

c. Heel To Shin

	Quickly and Accurately	Moderate Incoordination	Clumsily	Unable to Perform
Left	●	MI	C	UP
Right	●	MI	C	UP

d. Romberg's Test ○ Negative ○ Positiv

e. Finger To Finger ○ Smoothly & Easily ○ Positiv

f. Finger To Nose ○ Smoothly & Easily ○ Positiv

g. Other 1 − + _____

h. Other 2 − + _____

C. NEUROLOGICAL ASSESSMENT (CONTINUED)

4. DEEP TENDON REFLEXES

○ Grade 2 and Symmetric / Except:

		Left						Right					
		0	1	2	3	4	5	0	1	2	3	4	5
Biceps	(C5)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Brachioradialis	(C6)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Triceps	(C7)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤

(2=Normal)

○ Grade 2 and Symmetric / Except:

Patellar	(L4)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Medial Hamstring	(L5)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Achilles	(S1)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤

5. MOTOR EXAMINATION

a. Upper Extremity Motor Function (Cervical/Brachial Muscle Testing)

○ No Muscle Weakness / Except:
(5=Normal)

		Left						Right					
		0	1	2	3	4	5	0	1	2	3	4	5
Shoulder Flexion		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Shoulder Extension		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Shoulder Abduction	(C5)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Shoulder Adduction		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Internal Rotation		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
External Rotation		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Elbow Flexion	(C6)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Elbow Extension	(C7)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Wrist Flexion	(C7)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Wrist Extension	(C6)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Finger Flexion	(C8)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Finger Extension	(C7)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Finger Abduction	(T1)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Finger Adduction	(T1)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Other 1		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Other 2		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤

Of Additional Note ○

b. Lower Extremity Motor Function (Lumbar/Lumbosacral Muscle Testing)

● No Muscle Weakness / Except:
(5=Normal)

		Left						Right					
		0	1	2	3	4	5	0	1	2	3	4	5
Hip Flexion	(T12 - L3)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Hip Extension	(S1)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Hip Abduction	(L5)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Hip Adduction	(L2-L4)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Leg Flexion	(L5-S2)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Leg Extension	(L2-L4)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Foot Dorsiflexion	(L4)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Great Toe Dorsiflexion	(L5)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Foot Plantar Flexion	(S1)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Great Toe Plantar Flexion		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Foot Eversion	(S1)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Foot Inversion	(L4)	⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Other 1		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤
Other 2		⓪	①	②	③	④	⑤	⓪	①	②	③	④	⑤

Of Additional Note ○

6. MENSURATION (In Centimeters, measuring girth)

Left Bicep	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units
Right Bicep	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units
Left Forearm	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units
Right Forearm	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units
Left Thigh	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units
Right Thigh	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units
Left Calf	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units
Right Calf	⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪	Tens
	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	Units

7. DERMATOMAL SENSORY TESTING

○ No Sensory Deficit / Except: (NSD/E:)

	Hypo		Hyper	
	L	R	L	R
C1	Ⓛ	Ⓡ	Ⓛ	Ⓡ
C2	Ⓛ	Ⓡ	Ⓛ	Ⓡ
C3	Ⓛ	Ⓡ	Ⓛ	Ⓡ
C4	Ⓛ	Ⓡ	Ⓛ	Ⓡ
C5	Ⓛ	Ⓡ	Ⓛ	Ⓡ
C6	Ⓛ	Ⓡ	Ⓛ	Ⓡ
C7	Ⓛ	Ⓡ	Ⓛ	Ⓡ
C8	Ⓛ	Ⓡ	Ⓛ	Ⓡ

○ NSD/E:

	Hypo		Hyper	
	L	R	L	R
L1	Ⓛ	Ⓡ	Ⓛ	Ⓡ
L2	Ⓛ	Ⓡ	Ⓛ	Ⓡ
L3	Ⓛ	Ⓡ	Ⓛ	Ⓡ
L4	Ⓛ	Ⓡ	Ⓛ	Ⓡ
L5	Ⓛ	Ⓡ	Ⓛ	Ⓡ

○ NSD/E:

	Hypo		Hyper	
	L	R	L	R
T1	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T2	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T3	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T4	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T5	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T6	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T7	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T8	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T9	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T10	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T11	Ⓛ	Ⓡ	Ⓛ	Ⓡ
T12	Ⓛ	Ⓡ	Ⓛ	Ⓡ

○ NSD/E:

	Hypo		Hyper	
	L	R	L	R
S1	Ⓛ	Ⓡ	Ⓛ	Ⓡ
S2	Ⓛ	Ⓡ	Ⓛ	Ⓡ
S3	Ⓛ	Ⓡ	Ⓛ	Ⓡ
S4	Ⓛ	Ⓡ	Ⓛ	Ⓡ
S5	Ⓛ	Ⓡ	Ⓛ	Ⓡ

8. HEEL WALK

	Able To Perform	Able With Assistance	Unable To Perform
Left	●	ⒶⒶ	Ⓤ
Right	●	ⒶⒶ	Ⓤ

9. TOE WALK

	Able To Perform	Able With Assistance	Unable To Perform
Left	●	ⒶⒶ	Ⓤ
Right	●	ⒶⒶ	Ⓤ

10. PLANTAR RESPONSE

	Plantar flexion (normal)	Dorsiflexion (Babinski's sign)	Absent
Left	Ⓝ	●	Ⓐ
Right	Ⓝ	●	Ⓐ

11. HOFFMAN'S SIGN

	(-)	(+)
Left	⊖	⊕
Right	⊖	⊕

C. NEUROLOGICAL ASSESSMENT (CONTINUED)

12. DYNAMOMETER (Measured in Pounds)

1st Attempt				2nd Attempt				3rd Attempt			
Left			Right	Left			Right	Left			Right
H	T	U	H T U	H	T	U	H T U	H	T	U	H T U
100	10	1	100 10 1	100	10	1	100 10 1	100	10	1	100 10 1
	20	2	20 2		20	2	20 2		20	2	20 2
	30	3	30 3		30	3	30 3		30	3	30 3
	40	4	40 4		40	4	40 4		40	4	40 4
	50	5	50 5		50	5	50 5		50	5	50 5
	60	6	60 6		60	6	60 6		60	6	60 6
	70	7	70 7		70	7	70 7		70	7	70 7
	80	8	80 8		80	8	80 8		80	8	80 8
	90	9	90 9		90	9	90 9		90	9	90 9

13. OF ADDITIONAL NOTE

A B C D E F G H I J K L M

D. ORTHOPEDIC EXAM OF THE SPINE

1. CERVICAL SPINE

a. Range Of Motion

Normal In All Positions / Except: (2 Exceptions)

(*Normal Cervical ROM is based on the 2001 AMA Guide To The Evaluation Of Permanent Impairment)

	Normal*									Dull Pain	Sharp Pain	Spinal Level Of:	Radiates To:
Flexion	50	10	20	30	40	50	60	70	80	90	D	S	L	L
	N	1	2	3	4	5	6	7	8	9				R
Extension	60	10	20	●	40	50	60	70	80	90	●	S	L	L
	N	1	2	3	4	5	6	7	8	9				R
Lt Lateral Flexion	45	10	20	30	40	50	60	70	80	90	D	S	L	L
	N	1	2	3	4	5	6	7	8	9				R
Rt Lateral Flexion	45	10	20	30	40	50	60	70	80	90	D	S	L	L
	N	1	2	3	4	5	6	7	8	9				R
Left Rotation	80	10	20	30	40	50	60	70	80	90	D	S	L	L
	N	1	2	3	4	5	6	7	8	9				R
Right Rotation	80	10	20	30	40	50	60	70	80	90	D	S	L	L
	N	1	2	3	4	5	6	7	8	9				R

b. Cervical Muscle Testing

No Muscle Weakness / Except: (2 Exceptions)

		Left						Right					
		0	1	2	3	4	5	0	1	2	3	4	5
SCM	(CN XI)	0	1	2	3	4	5	0	1	2	3	4	5
Trapezius	(CN XI)	0	1	2	3	4	5	0	1	2	3	4	5
Flexors	(C1-6)	0	1	2	3	4	5	0	1	2	3	4	5
Extensors	(C1-T1)	0	1	2	3	4	5	0	1	2	3	4	5

c. Compression Tests

1. Cervical Compression Test

Negative In All Positions / Except: (2 Exceptions)

	(-)	(+)	Left: Dull	Sharp	Pares	Cerv	Shldr	Arm	Hand/Fngrs	Right: Dull	Sharp	Pares	Cerv	Shldr	Arm	Hand/Fngrs
Neutral	⊖	⊕	D	S	P	C	S	E	H	D	S	P	C	S	E	H
Lt Lat Flex	⊖	⊕	D	S	P	C	S	E	H	D	S	P	C	S	E	H
Rt Lat Flex	⊖	⊕	D	S	P	C	S	E	H	D	S	P	C	S	E	H
Lt Max Cmp	⊖	⊕	D	S	P	C	S	E	H	D	S	P	C	S	E	H
Rt Max Cmp	⊖	⊕	D	S	P	C	S	E	H	D	S	P	C	S	E	H

2. Adson's Test

	(-)	(+)	Pulse	Paresthesia
Left	⊖	⊕	D	P
Right	⊖	⊕	D	P

3. Valsalva

(-)	(+) Pain			Head	Cervical	Upr Thoracic	Lt Upr Extr	Rt Upr Extr	Other
⊖	+	++	+++	H	C	T	L	R	O

d. Stretch Tests

1. Shoulder Depression

	(-)	(+) Pain			Cervical	Shoulder	Arm	Hand/Fngrs	Other
Left	⊖	+	++	+++	C	S	E	H	O
Right	⊖	+	++	+++	C	S	E	H	O

2. Soto Hall

	(-)	(+) Pain			Head	Cervical	Thoracic	Upper Extr	Other
Left	⊖	+	++	+++	H	C	T	U	O
Right	⊖	+	++	+++	H	C	T	U	O

e. Distraction Tests

		(-)	(+) Pain			↑ Pain	↓ Pain	Cervical	Other
Cervical Distraction		⊖	+	++	+++	I	D	C	O
Bakody's Sign	Left	⊖	+	++	+++	I	D	C	O
	Right	⊖	+	++	+++	I	D	C	O
O'Donoghue's	Passive	⊖	+	++	+++				
	Active	⊖	+	++	+++				

f. Other 1 ⊖ ⊕

g. Other 2 ⊖ ⊕

h. Other 3 ⊖ ⊕

i. Of Additional Note 1 2 3 4 5 6 7 8 9 10 11 12

2. THORACIC SPINE

a. Range Of Motion

Normal In All Positions / Except: (2 Exceptions)

(*Normal Thoracic ROM is based on the 2001 AMA Guide To The Evaluation Of Permanent Impairment)

	Normal*									Dull Pain	Sharp Pain	Spinal Level:
Flexion	60	10	20	30	40	50	60	70	80	90	D	S	L
	N	1	2	3	4	5	6	7	8	9			
Extension	25	10	20	30	40	50	60	70	80	90	D	S	L
	N	1	2	3	4	5	6	7	8	9			
Lt Lateral Flexion	25	10	20	30	40	50	60	70	80	90	D	S	L
	N	1	2	3	4	5	6	7	8	9			
Rt Lateral Flexion	25	10	20	30	40	50	60	70	80	90	D	S	L
	N	1	2	3	4	5	6	7	8	9			
Left Rotation	45	10	20	30	40	50	60	70	80	90	D	S	L
	N	1	2	3	4	5	6	7	8	9			
Right Rotation	45	10	20	30	40	50	60	70	80	90	D	S	L
	N	1	2	3	4	5	6	7	8	9			

b. Thoracic/Torso Muscle Testing

No Muscle Weakness / Except:

	Left						Right					
	0	1	2	3	4	5	0	1	2	3	4	5
Torso Flexors	0	1	2	3	4	5	0	1	2	3	4	5
Torso Extensors	0	1	2	3	4	5	0	1	2	3	4	5
Lateral Flexors	0	1	2	3	4	5	0	1	2	3	4	5

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D. ORTHOPEDIC EXAM OF THE SPINE (Continued)

2. THORACIC SPINE (Continued)

c. Mechanical Tests

1. Chest Expansion Test

(-)	(+)		½	1	1½	2
−	+	Decrease In Inches	½	1	1½	2

2. Sternal Compression Test

(-)	(+) Pain	Location Of
−	+ ++ +++	

3. Beevor's Sign

(-)	(+) Pain	Sup. Movt.	Inf. Movt.
−	+ ++ +++	S	I

d. Stretch Test

Schepelmann's Sign

	(-)	(+) Pain	Concave	Convex
Left	−	+ ++ +++	CC	CV
Right	−	+ ++ +++	CC	CV

e. Other 1 − +

f. Other 2 − +

g. Other 3 − +

h. Of Additional Note 1 2 3 4 5 6 7 8 9 10 11 12 13

3. LUMBAR SPINE

a. Range Of Motion

Normal In All Positions / Except (2 Exceptions):

	Normal*	(*Normal Lumbar ROM is based on the 2001 AMA Guide To The Evaluation Of Permanent Impairment)	Dull Pain	Sharp Pain	Spinal Level Of:	Radiates To:
Sacral Hip Angle	45	10 20 30 40 50 60 70 80 90	D	S	L	L
	N	1 2 3 4 5 6 7 8 9				R
True Lum Flexion	60	10 20 40 50 60 70 80 90		S	L	L
	N	1 2 3 4 5 6 7 8 9				R
Extension	25	10 20 30 40 50 60 70 80 90	D	S	L	L
	N	1 2 3 4 5 6 7 8 9				R
Lt Lateral Flexion	25	10 20 30 40 50 60 70 80 90	D	S	L	L
	N	1 2 3 4 5 6 7 8 9				R
Rt Lateral Flexion	25	10 20 30 40 50 60 70 80 90	D	S	L	L
	N	1 2 3 4 5 6 7 8 9				R

b. Compression Tests

1. Valsalva

(-)	(+) Pain	Lumbar	Lt Lwr Ext	Rt Lwr Ext	Other
−	+ ++ +++	L	LL	RL	O

2. Iliac Compression Test

(-)	(+) Pain	Lt SI Joint	Rt SI Joint	Other
−	+ ++ +++	L	R	O

3. Kemp's Test

	(-)	(+) Pain	Low Back	Ant Thigh	Pos Thigh	Leg (below the knee)	Leaning into	Lean Away
Left	−	+ ++ +++	LB	A	P	L	LI	LA
Right	−	+ ++ +++		A	P	L	LI	LA

c. Mechanical Test (Hip and Pelvis Included)

		(-)	(+) Pain	Hip	SI	Lumbar
FABERE- Patrick's	Left	−	+ ++ +++	H	S	L
	Right	−	+ ++ +++	H	S	L
Gaenslen's Test	Left	−	+ ++ +++	H	S	L
	Right	−	+ ++ +++	H	S	L
Thomas Test	Left	−	+ ++ +++	H	S	L
	Right	−	+ ++ +++	H	S	L
Yeoman's Test	Left	−	+ ++ +++		S	L
	Right	−	+ ++ +++		S	L
Hibb's Test	Left	−	+ ++ +++	H	S	L
	Right	−	+ ++ +++	H	S	L
Goldwaith's Test	Left	−	+ ++ +++		S	L
	Right	−	+ ++ +++		S	L
Trendelenberg's Test	Left	−	+ ++ +++			
	Right	−	+ ++ +++			

d. Root Tension Signs (Stretch Tests)

		(-)	(+) Pain	Low Back	Posterior Thigh	Leg (Below Knee)	1. 0-30	2. 35-70	3. 70-90	Other
Straight Leg Raise	Lt	−	+ ++ +++	B	T	L	1	2	3	O
	Rt	−	+ ++ +++	B	T	L	1	2	3	O
Braggard's Test	Lt	−	+ ++ +++	B	T	L	1	2	3	O
	Rt	−	+ ++ +++	B	T	L	1	2	3	O
Well Leg Raise	Lt	−	+ ++ +++	B	T	L	1	2	3	O
	Rt	−	+ ++ +++	B	T	L	1	2	3	O
Fajersztajn's Test	Lt	−	+ ++ +++	B	T	L	1	2	3	O
	Rt	−	+ ++ +++	B	T	L	1	2	3	O
Kernig's Test	Lt	−	+ ++ +++	B	T	L	1	2	3	O
	Rt	−	+ ++ +++	B	T	L	1	2	3	O
Sitting Leg Raise	Lt	−	+ ++ +++	B	T	L	1	2	3	O
	Rt	−	+ ++ +++	B	T	L	1	2	3	O

Milgram's Test	Lt	− + ++ +++
	Rt	− + ++ +++

		(-)	(+) Pain	Low Back	Ant Thigh
Ely's Test	Lt	−	+ ++ +++	B	T
	Rt	−	+ ++ +++	B	T
Nachlas Test	Lt	−	+ ++ +++	B	T
	Rt	−	+ ++ +++	B	T

e. Other 1 − +

f. Other 2 − +

g. Other 3 − +

h. Of Additional Note 1 2 3 4 5 6 7 8 9 10 11 12 13 14

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E. SPINAL EXAMINATION

		EDEMA L M R	SPASM L M R	TENDERNESS LEFT-Grades	TENDERNESS L M R	TENDERNESS RIGHT-Grades	TRIGGER POINTS L M R	ARTICULAR FIXATION L M R	MAL-POSITION L M R
U	OCC	L M R	OCC L M R	OCC 4 3 2 1	L M R	1 2 3 4	OCC L M R	OCC L M R	OCC L M R
U	C1	L M R	C1 L M R	C1 4 3 2 1	L M R	1 2 3 4	C1 L M R	C1 L M R	C1 L M R
U	C2	L M R	C2 L M R	C2 4 3 2 1	L M R	1 2 3 4	C2 L M R	C2 L M R	C2 L M R
M	C3	L M R	C3 L M R	C3 4 3 2 1	L M R	1 2 3 4	C3 L M R	C3 L M R	C3 L M R
M	C4	L M R	C4 L M R	C4 4 3 2 1	L M R	1 2 3 4	C4 L M R	C4 L M R	C4 L M R
L	C5	L M R	C5 L M ●	C5 4 3 2 1	L M ●	1 2 3 4	C5 L M R	C5 L ● R	C5 L M R
L	C6	L M R	C6 L M ●	C6 4 3 2 1	L M ●	1 2 3 4	C6 L M R	C6 L ● R	C6 L M R
L	C7	L M R	C7 L M ●	C7 4 3 2 1	L M ●	1 2 3 4	C7 L M R	C7 L ● R	C7 L M R

○ None ○ Note (Cervical)

U	T1	L M R	T1 L M R	T1 4 3 2 1	L M R	1 2 3 4	T1 L M R	T1 L M R	T1 L M R
U	T2	L M R	T2 L M R	T2 4 3 2 1	L M R	1 2 3 4	T2 L M R	T2 L M R	T2 L M R
U	T3	L M R	T3 L M R	T3 4 3 2 1	L M R	1 2 3 4	T3 L M R	T3 L M R	T3 L M R
U	T4	L M R	T4 L M R	T4 4 3 2 1	L M R	1 2 3 4	T4 L M R	T4 L M R	T4 L M R
M	T5	L M R	T5 L M R	T5 4 3 2 1	L M R	1 2 3 4	T5 L M R	T5 L M R	T5 L M R
M	T6	L M R	T6 L M R	T6 4 3 2 1	L M R	1 2 3 4	T6 L M R	T6 L M R	T6 L M R
M	T7	L M R	T7 L M R	T7 4 3 2 1	L M R	1 2 3 4	T7 L M R	T7 L M R	T7 L M R
M	T8	L M R	T8 L M R	T8 4 3 2 1	L M R	1 2 3 4	T8 L M R	T8 L M R	T8 L M R
L	T9	L M R	T9 L M R	T9 4 3 2 1	L M R	1 2 3 4	T9 L M R	T9 L M R	T9 L M R
L	T10	L M R	T10 L M R	T10 4 3 2 1	L M R	1 2 3 4	T10 L M R	T10 L M R	T10 L M R
L	T11	L M R	T11 L M R	T11 4 3 2 1	L M R	1 2 3 4	T11 L M R	T11 L M R	T11 L M R
L	T12	L M R	T12 L M R	T12 4 3 2 1	L M R	1 2 3 4	T12 L M R	T12 L M R	T12 L M R

○ None ○ NOTE (Thoracic)

U	L1	L M R	L1 L M R	L1 4 3 2 1	L M R	1 2 3 4	L1 L M R	L1 L M R	L1 L M R
U	L2	L M R	L2 L M R	L2 4 3 2 1	L M R	1 2 3 4	L2 L M R	L2 L M R	L2 L M R
M	L3	L M R	L3 L M R	L3 4 3 2 1	L M R	1 2 3 4	L3 L M R	L3 L M R	L3 L M R
L	L4	L M R	L4 L M R	L4 4 3 2 1	L M R	1 2 3 4	L4 L M R	L4 L M R	L4 L M R
L	L5	L M R	L5 ● M ●	L5 4 3 2 1	● ● ●	1 2 3 4	L5 L M R	L5 L ● R	L5 L M R

○ None ○ NOTE (Lumbar)

	SAC	L M R	SAC L M R	SAC 4 3 2 1	L M R	1 2 3 4	SAC L M R	SAC L M R	SAC L M R
	S-I	L R	S-I L R	S-I 4 3 2 1	L R	1 2 3 4	S-I L R	S-I L R	S-I L R
	COC	L M R	COC L M R	COC 4 3 2 1	L M R	1 2 3 4	COC L M R	COC L M R	COC L M R

○ None ○ NOTE (Sacro-pelvic)

ALGOMETER ○ PSI ○ Kgs/cm²

	LEFT	MIDLINE	RIGHT
OCC	L	M	R
C1	L	M	R
C2	L	M	R
C3	L	M	R
C4	L	M	R
C5	L	M	R
C6	L	M	R
C7	L	M	R
T1	L	M	R
T2	L	M	R
T3	L	M	R
T4	L	M	R
T5	L	M	R
T6	L	M	R
T7	L	M	R
T8	L	M	R
T9	L	M	R
T10	L	M	R
T11	L	M	R
T12	L	M	R
L1	L	M	R
L2	L	M	R
L3	L	M	R
L4	L	M	R
L5	L	M	R
SAC	L	M	R
S-I	L		R
COC	L	M	R

F. EXTREMITY EVALUATION

Upper Extremities	Left	Right	Palpation	ROM	Muscle Test	Ortho Test	Assesment	Treatment	FINDINGS
Shoulder	L	R	P	R	M	O	A	T	
AC Joint	L	R	P	R	M	O	A	T	
Clavicle/SC Joint	L	R	P	R	M	O	A	T	
Elbow	L	R	P	R	M	O	A	T	
Wrist	L	R	P	R	M	O	A	T	
Hand/Digits	L	R	P	R	M	O	A	T	
Ribs	L	R	P	R	M	O	A	T	
Scapula	L	R	P	R	M	O	A	T	
1.	L	R	P	R	M	O	A	T	
2.	L	R	P	R	M	O	A	T	

Lower Extremities	Left	Right	Palpation	ROM	Muscle Test	Ortho Test	Assesment	Treatment	FINDINGS
Psoas	L	R	P	R	M	O	A	T	
Hip	L	R	P	R	M	O	A	T	
Knee	L	R	P	R	M	O	A	T	
Tibia	L	R	P	R	M	O	A	T	
Fibula	L	R	P	R	M	O	A	T	
Ankle	L	R	P	R	M	O	A	T	
Foot/Digits	L	R	P	R	M	O	A	T	
1.	L	R	P	R	M	O	A	T	
2.	L	R	P	R	M	O	A	T	

G. ASSESSMENT

1. CERVICAL

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
307.81	Tension Headache	P	S	O	A	Su	C	M	Mo	Se
346.90	Migraine Headache	P	S	O	A	Su	C	M	Mo	Se
353.0	Brachial Plexus Lesions	P	S	O	A	Su	C	M	Mo	Se
524.60	TMJ Syndrome	P	S	O	A	Su	C	M	Mo	Se
721.0	Spondylosis W/O Mye	P	S	O	A	Su	C	M	Mo	Se
721.1	Neuro Vascular Comp Synd	P	S	O	A	Su	C	M	Mo	Se
722.0	Disc Displacement W/O Mye	P	S	O	A	Su	C	M	Mo	Se
722.4	Disc Degeneration	●	S	O	A	Su	C	M	Mo	Se
722.71	Disc Displacement W/Mye	P	S	O	A	Su	C	M	Mo	Se
722.81	Postlaminectomy Syndrome	P	S	O	A	Su	C	M	Mo	Se
723.0	Spinal Stenosis	P	S	O	A	Su	C	M	Mo	Se
723.1	Cervicalgia	P	S	O	A	Su	C	M	Mo	Se
723.2	Cervicocranial Syndrome	●	S	O	A	Su	C	M	Mo	Se
723.3	Cervicobrachial Syndrome	P	S	O	A	Su	C	M	Mo	Se
723.4	Radiculitis	P	S	O	A	Su	C	M	Mo	Se
723.5	Torticollis	P	S	O	A	Su	C	M	Mo	Se
724.9	Nerve Root Compression	P	S	O	A	Su	C	M	Mo	Se
728.5	Hypermobility Syndrome	P	S	O	A	Su	C	M	Mo	Se
728.85	Muscle Spasm	P	S	O	A	Su	C	M	Mo	Se
729.1	Myalgia / Myofascitis	P	S	O	A	Su	C	M	Mo	Se
737.10	Kyphosis	P	S	O	A	Su	C	M	Mo	Se
739.1	Segmental/Somatic Dys/Cerv	P	●	O	A	Su	C	M	Mo	Se
756.10	Spinal Anomaly	P	S	O	A	Su	C	M	Mo	Se
780.4	Dizziness/Vertigo	P	S	O	A	Su	C	M	Mo	Se
784.0	Headaches	P	S	O	A	Su	C	M	Mo	Se
805.00	Compression Fracture	P	S	O	A	Su	C	M	Mo	Se
839.00	Subluxation/Cervical Vertebra	P	S	O	A	Su	C	M	Mo	Se
839.08	Multiple Subluxations	P	S	O	A	Su	C	M	Mo	Se
847.0	Sprain/Strain	P	S	O	A	Su	C	M	Mo	Se
952.00	Injury to Nerves (C1/C4)	P	S	O	A	Su	C	M	Mo	Se
952.05	Injury To Nerves (C5/C7)	P	S	O	A	Su	C	M	Mo	Se
Other 1		P	S	O	A	Su	C	M	Mo	Se
Other 2		P	S	O	A	Su	C	M	Mo	Se

2. THORACIC

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
353.9	Cerv Dorsal Outlet Syndrome	P	S	O	A	Su	C	M	Mo	Se
722.11	Disc Displacement W/O Mye	P	S	O	A	Su	C	M	Mo	Se
722.51	Disc Degeneration	P	S	O	A	Su	C	M	Mo	Se
722.72	Disc Displacement W/Mye	P	S	O	A	Su	C	M	Mo	Se
724.1	Thoracalgia	P	S	O	A	Su	C	M	Mo	Se
724.4	Thoracic Neuritis/Radiculitis	P	S	O	A	Su	C	M	Mo	Se
728.85	Muscle Spasm	P	S	O	A	Su	C	M	Mo	Se
729.1	Myalgia / Myoscitis	P	S	O	A	Su	C	M	Mo	Se
737.30	Scoliosis	P	S	O	A	Su	C	M	Mo	Se
739.2	Segmental/Somatic Dysfunction	P	S	O	A	Su	C	M	Mo	Se
786.50	Chest Pain	P	S	O	A	Su	C	M	Mo	Se
839.21	Subluxation/Thoracic Region	P	S	O	A	Su	C	M	Mo	Se
847.1	Sprain/Strain	P	S	O	A	Su	C	M	Mo	Se
848.3	Rib/Intercostal Strain	P	S	O	A	Su	C	M	Mo	Se
Other 1		P	S	O	A	Su	C	M	Mo	Se
Other 2		P	S	O	A	Su	C	M	Mo	Se

3. LUMBAR

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
720.1	Spinal Enthesopathy	P	S	O	A	Su	C	M	Mo	Se
721.3	Spondylosis W/O Mye	P	S	O	A	Su	C	M	Mo	Se
721.42	Spondylosis W/Mye	P	S	O	A	Su	C	M	Mo	Se
722.10	Disc Displacement W/O Mye	●	S	O	A	Su	C	M	Mo	Se
722.52	Disc Degeneration	P	S	O	A	Su	C	M	Mo	Se

3. LUMBAR (Continued)

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
722.73	Disc Displacement W/Mye	P	S	O	A	Su	C	M	Mo	Se
722.83	Postlaminectomy Syndrome	P	S	O	A	Su	C	M	Mo	Se
724.02	Spinal Stenosis	P	S	O	A	Su	C	M	Mo	Se
724.2	Low Back Pain	P	S	O	A	Su	C	M	Mo	Se
724.3	Sciatica	P	S	O	A	Su	C	M	Mo	Se
724.4	Lumbar Neuritis/Radiculitis	P	S	O	A	Su	C	M	Mo	Se
724.5	Backache, Unspecified	●		O	A	Su	C	M	Mo	Se
724.8	Facet Syndrome	P	S	O	A	Su	C	M	Mo	Se
728.85	Muscle Spasm	P	S	O	A	Su	C	M	Mo	Se
729.01	Myalgia / Myoscitis	P	S	O	A	Su	C	M	Mo	Se
739.3	Segmental/Somatic Dys	P	S	O	A	Su	C	M	Mo	Se
756.11	Spondylosis	P	S	O	A	Su	C	M	Mo	Se
756.12	Spondylolisthesis	P	S	O	A	Su	C	M	Mo	Se
756.15	Anomaly/Congenital	P	S	O	A	Su	C	M	Mo	Se
805.4	Compression Fracture	P	S	O	A	Su	C	M	Mo	Se
839.20	Subluxation/Lumbar	P	S	O	A	Su	C	M	Mo	Se
847.2	Lumbar Sprain/Strain	P	S	O	A	Su	C	M	Mo	Se
953.2	Nerve Injury/Lumbar Root	P	S	O	A	Su	C	M	Mo	Se
Other 1		P	S	O	A	Su	C	M	Mo	Se
Other 2		P	S	O	A	Su	C	M	Mo	Se
Other 3		P	S	O	A	Su	C	M	Mo	Se

4. LUMBOSACRAL

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
724.4	Lumbosacral Neuritis	P	S	O	A	Su	C	M	Mo	Se
728.5	Hypermobility Syndrome	P	S	O	A	Su	C	M	Mo	Se
738.4	Spondylolisthesis (Aquired)	P	S	O	A	Su	C	M	Mo	Se
756.10	Spinal Anomaly	P	S	O	A	Su	C	M	Mo	Se
846.0	Spain/Strain	P	S	O	A	Su	C	M	Mo	Se
Other 1		P	S	O	A	Su	C	M	Mo	Se
Other 2		P	S	O	A	Su	C	M	Mo	Se

5. SACROILIAC

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
720.2	Inflammation of SI	P	S	O	A	Su	C	M	Mo	Se
724.6	Disorder of Sacrum	P	S	O	A	Su	C	M	Mo	Se
739.4	Segmental/Somatic Dys	P	S	O	A	Su	C	M	Mo	Se
839.42	Subluxation of SI Joint	P	S	O	A	Su	C	M	Mo	Se
846.1	Sprain/Strain Sac Lig	P	S	O	A	Su	C	M	Mo	Se
847.3	Sprain/Strain Sacrum	P	S	O	A	Su	C	M	Mo	Se
Other 1		P	S	O	A	Su	C	M	Mo	Se
Other 2		P	S	O	A	Su	C	M	Mo	Se

6. PELVIS

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
736.81	Limb Shortening (Acquired)	P	S	O	A	Su	C	M	Mo	Se
739.5	Segmental/Somatic Dys	P	S	O	A	Su	C	M	Mo	Se
755.30	Limb Shortening (Congenital)	P	S	O	A	Su	C	M	Mo	Se
781.9	Abnormal Posture	P	S	O	A	Su	C	M	Mo	Se
839.41	Coccyx Subluxation	P	S	O	A	Su	C	M	Mo	Se
839.69	Pelvis Subluxation	P	S	O	A	Su	C	M	Mo	Se
847.4	Coccyx Sprain/Strain	P	S	O	A	Su	C	M	Mo	Se
Other 1		P	S	O	A	Su	C	M	Mo	Se
Other 2		P	S	O	A	Su	C	M	Mo	Se

7. GENERAL

		Primary	Secondary	Other	Acute	Subacute	Chronic	Mild	Moderate	Severe
715.00	Osteoarthrosis	P	S	O	A	Su	C	M	Mo	Se
728.4	Ligamentous Instability C/T/L	P	S	O	A	Su	C	M	Mo	Se
733.00	Osteoporosis	P	S	O	A	Su	C	M	Mo	Se
733.01	Senile Osteoporosis	P	S	O	A	Su	C	M	Mo	Se
Other 1		P	S	O	A	Su	C	M	Mo	Se
Other 2		P	S	O	A	Su	C	M	Mo	Se
Other 3		P	S	O	A	Su	C	M	Mo	Se
Other 4		P	S	O	A	Su	C	M	Mo	Se

H. PLAN - RECOMMENDED MANAGEMENT

1. TREATMENTS

a. Manual Therapies

	Specific Spinal	Spinal Distractive	Instrument Adjustment	Myofascial Release	Joint Mobilization	Other 1	Other 2
Cervical	●	SD	A	M	J	O1	O1
Thoracic	SS	SD	A	M	J	O1	O1
Lumbar	SS	SD	A	M	J	O1	O1
Sacrum	SS	●	A	M	J	O1	O1
Pelvis	SS	SD	A	M	J	O1	O1

b. Physical Modalities

	Head	Cervical			Thoracic			Lumbar			Sacrum			Pelvis	
		U	M	L	U	M	L	U	M	L	Lt	M	Rt	Lt	Rt
Cryotherapy	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Diathermy	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Thermotherapy	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
TENS	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Man. Traction		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Mech. Traction		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Massage	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Ultrasound		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Ischemic Comp		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
LV Galvanic		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
HV Galvanic		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Interferential		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Russian Stim		UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Other 1	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Other 2	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Other 3	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP
Other 4	H	UC	MC	LC	UT	MT	LT	UL	ML	LL	LS	MS	RS	LP	RP

c. Rehabilitation Recommendations - In Office

○ Cervical	
○ Thoracic	
○ Lumbar	
○ Sacrum	
○ Pelvic	
○ Other	

2. TREATMENT GOALS

○ Relief/Repair ○ Supportive
○ Rehabilitative(Remodeling) ○ Maintenance
○ Other_____

3. VISIT FREQUENCY

○ From___/___/___ ○ To___/___/___ ○ PRN

Per: Day ① ② ③ | Week ① ● ③ ④ ⑤ ⑥ ⑦

Weeks ① ② ③ ● ⑤ ⑥ ⑦ ⑧
Months ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

○ Other_____

4. VISITS THIS PLAN

a. Adjustments:

	Tens	Units
0-15 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
16-30 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
31-45 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
46-60 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

b. Therapies:

0-15 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
16-30 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
31-45 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
46-60 days	⑩ ⑳ ㉚ ㊵ ㊿	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

5. WORK STATUS

a. Able To Return To Work?

○ Unrestricted ○ With Restrictions ○ Unable

b. Restrictions (With Work, Or In General)

1. Avoid Prolonged:
   ○ Sitting ○ Standing ○ Walking ○ Jarring Motions
   ○ Other_____
2. Avoid Repetitive:
   ○ Bending ○ Reaching ○ Lifting ○ Turning
   ○ Push/Pull ○ Computer Work ○ Telephone Wor
   ○ Hand Use ○ Other_____
3. Avoid Lifting Over:
   Pounds: ⑤ ⑩ ⑮ ⑳ ㉕ ㊿ ○ Other_____

○ Time Frame on Restrictions?_____
○ Re-Evaluation Date To Review Work Status ___/___/___

6. HOME DUTIES RESTRICTIONS

○ Domestic Duties ○ Family Care ● Yard Maintenance
○ Other_____
For Weeks: ① ② ③ ● ⑤ ⑥ ○ Other_____

7. REHABILITATION FOR HOME USE

Pillows: ① ② ③_____ ○ Orthotics_____
Supports: ○ C_____ ○ T_____ ○ L_____
Others: ①_____ ②_____ ③_____
○ Supportive Exercise_____

8. RECOMMENDATIONS

If Patient Fails To Respond By: ○ ___/___/___ **Or** ● Re-eva

R=For Referral I=Immediate, or In Office

Ⓡ	Ⓘ	Urinalysis	Ⓡ	Ⓘ	Physiatric Consultation
Ⓡ	Ⓘ	Blood Analysis	Ⓡ	Ⓘ	Internal Medicine Consult.
Ⓡ	Ⓘ	Tissue Cultures	Ⓡ	Ⓘ	Neurological Consultation
Ⓡ	Ⓘ	Serological Analysis	Ⓡ	Ⓘ	Orthopedic Consultation
Ⓡ	Ⓘ	CT Examination	Ⓡ	Ⓘ	Rheumatologic Consult.
●	Ⓘ	MRI Examination	Ⓡ	Ⓘ	Nutritional Consultation
Ⓡ	Ⓘ	Electrodiagnosis Eval.	Ⓡ	Ⓘ	Other 1
Ⓡ	Ⓘ	N.C.V	Ⓡ	Ⓘ	Other 2

○ **Medications:**

○ **Supplements:**

9. CASE DESCRIPTION/ DISCUSSION (Any Additional Info.)

① ② ③ Ⓓ Disability

SCANTRON EW-223395-3:24

10. PROGNOSIS

○ Excellent ○ Good ○ Fair ○ Guarded ○ Poo
○ Other

11. ○ **All general measures associated with condition have been reviewed.**

12. ○ **Potential risks have been described and the patient has acknowledged their understanding of them.**

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PLEASE MAKE NO MARKS IN THIS AREA

RADIOGRAPHIC EXAMINATION

Exam Location: ● This Office ○ Include Images ○ Outside This Office _____

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

NO MARKS HERE

A. CERVICAL SPINE

1. VIEWS TAKEN ○ All Cervical Spine Within Normal Limits

● AP ● Lat ○ Flex ○ L.Obl ○ Other 1 _____
○ APOM ○ Vertex ○ Ext ○ R.Obl ○ Other 2 _____

2. OSSEOUS INSPECTION

a. Degenerative Changes ○ Within Normal Limits

OCC	Severity (Disc Hght: Mild / Moderate / Severe)	Disc Wedging (Ant / LL / RL / Post)	Listhesis (Body Position: Antr / LL / RL / Retro)	Instability w/Stress (Flx / Ext)	Foraminal Encroach (Lt / Rt)	Osteophyte / DJD (Ant / LL / RL / Post)	Disruption Spn-Lam
C1			1 1 1 1	1/2 1/2	1/2 1/2	1 1 1 1	1
C2	2/3 ● ++ +++	2/3 2/3 2/3 2/3	2 2 2 2	2/3 2/3	2/3 2/3	2 2 2 2	2
C3	3/4 ● ++ +++	3/4 3/4 3/4 3/4	3 3 3 3	3/4 3/4	3/4 3/4	3 3 3 3	3
C4	4/5 + ++ +++	4/5 4/5 4/5 4/5	4 4 4 4	4/5 4/5	4/5 4/5	4 4 4 4	4
C5	5/6 + ++ +++	5/6 5/6 5/6 5/6	5 5 5 5	5/6 5/6	5/6 5/6	5 5 5 5	5
C6	6/7 + ++ +++	6/7 6/7 6/7 6/7	6 6 6 6	6/7 6/7	6/7 6/7	6 6 6 6	6
C7	7/T1 + ++ +++	7/T1 7/T1 7/T1 7/T1	7 7 7 7	7/T1 7/T1	7/T1 7/T1	7 7 7 7	7
T1							

3. LINES OF MENSURATION

1. Ⓐ Ⓑ Ⓒ Ⓓ
2. Ⓐ Ⓑ Ⓒ Ⓓ
3. Ⓐ Ⓑ Ⓒ Ⓓ

b. Cervical Curve

○ Well Maintained	Reduced
● Straightened	+ Mild
○ Reversed	++ Mod

○ **Spine In Midline**

c. Spinous Rotation-Region

○ None	○ Lt	○ Rt
+ Mild	++ Mod	+++ Sevr

d. Lateral Listing-Region

○ None	○ Lt	○ Rt
+ Mild	++ Mod	+++ Sevr

e. Posterior Ponticle

○ None	○ Lt	○ Rt

○ **Vertebral Bodies Normal Size/Shape**

f. Spinal Compression Fractures

○ None	○ Present At Level _____
Wedging: ○ Anterior	○ Lt Lat ○ Rt Lat
○ Step Defect	○ Endplate Disruption
○ Zone of Impaction (Radiopaque Band)	

g. Lytic / Blastic Changes

○ None	○ Present At Level _____
○ Cortical Thick.	○ Localized Inc. Density
○ Moth-Eaten	○ Diffuse Inc. Density
○ Permeative	○ Ivory Vertebra Sign

h. General Osteoporosis

○ None	+ Mild	++ Mod	+++ Sevr
○ Without Fx Defect	○ With Fx Defect		

4. SOFT TISSUE ANOMALIES ○ None

Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ Ⓖ Ⓗ

5. OF ADDITIONAL NOTE/OBSERVATION

Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ Ⓖ Ⓗ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

NO MARKS HERE

B. THORACIC SPINE

1. VIEWS TAKEN ● All Thoracic Spine Within Normal Limits

● AP ○ Lat ○ Swimmer's ○ Other _____

2. OSSEOUS INSPECTION

a. Degenerative Changes ○ Within Normal Limits

	Disc Hght	Disc Wedging (Ant / LL / RL / Post)	Listhesis (Ant / LL / RL / Retro)	Osteophyte / DJD (Ant / LL / RL / Post)	Disrp Spn-Lam
T1	1/2	1/2 1/2 1/2 1/2	1 1 1 1	1 1 1 1	1
T2	2/3	2/3 2/3 2/3 2/3	2 2 2 2	2 2 2 2	2
T3	3/4	3/4 3/4 3/4 3/4	3 3 3 3	3 3 3 3	3
T4	4/5	4/5 4/5 4/5 4/5	4 4 4 4	4 4 4 4	4
T5	5/6	5/6 5/6 5/6 5/6	5 5 5 5	5 5 5 5	5
T6	6/7	6/7 6/7 6/7 6/7	6 6 6 6	6 6 6 6	6
T7	7/8	7/1 7/1 7/1 7/1	7 7 7 7	7 7 7 7	7
T8	8/9	8/9 8/9 8/9 8/9	8 8 8 8	8 8 8 8	8
T9	9/1	9/1 9/1 9/1 9/1	9 9 9 9	9 9 9 9	9
T10	0/1	0/1 0/1 0/1 0/1	10 10 10 10	10 10 10 10	10
T11	1/2	1/2 1/2 1/2 1/2	11 11 11 11	11 11 11 11	11
T12	2/1	2/1 2/1 2/1 2/1	12 12 12 12	12 12 12 12	12
L1					

○ **Spine In Midline**

c. Spinous Rotation-Regn.

○ None	○ Lt	○ Rt
+ Mild	++ Mod	+++ Sevr

d. Lateral Listing-Region

○ None	○ Lt	○ Rt
+ Mild	++ Mod	+++ Sevr

e. Scoliosis

	Lt	Rt	Mild	Mod	Sevr
Primary	Ⓛ	Ⓡ	+	++	+++
Compens	Ⓛ	Ⓡ	+	++	+++

Apex Level: 1/2 2/3 3/4 4/5 5/6 6/7 7/8 8/9 9/1 0/1 1/2

b. Thoracic Curve

○ Well Maintained	+ Mild
○ Hyperkyphotic	++ Mod
○ Hypokyphotic	+++ Sevr

○ **Vertebral Bodies Normal Size/Shape**

g. Spinal Compression Fractures

○ None	○ Present At Level _____
Wedging: ○ Anterior	○ Lt Lat ○ Rt Lat
○ Step Defect	○ Endplate Disruption
○ Zone of Impaction (Radiopaque Band)	

h. Lytic / Blastic Changes

○ None	○ Present At Level _____
○ Cortical Thick.	○ Localized Inc Density
○ Moth-Eaten	○ Diffuse Inc. Density
○ Permeative	○ Ivory Vertebra Sign

i. General Osteoporosis

○ None	+ Mild	++ Mod	+++ Sevr
○ Without Fx Defect	○ With Fx Defect		

f. Hypoplastic 12th Ribs

○ Lt	○ Rt

--- Continued On Next Page ---

B. THORACIC SPINE - CONTINUED

3. LINES OF MENSURATION

1. Ⓐ Ⓑ Ⓒ Ⓓ
2. Ⓐ Ⓑ Ⓒ Ⓓ
3. Ⓐ Ⓑ Ⓒ Ⓓ

4. SOFT TISSUE ANOMALIES ○ None

Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ Ⓖ Ⓗ

5. OF ADDITIONAL NOTE/OBSERVATION

Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ Ⓖ Ⓗ Ⓘ | ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

C. LUMBOSACRAL SPINE

1. VIEWS TAKEN ○ All Lumbosacral Spine Within Normal Limits

● AP ○ Lat ○ L.Obl ○ R.Obl ○ L5/S1 Spot ○ AP Sac ○ Lat Sac ○ Other 1 ○ Other 2

2. OSSEOUS INSPECTION

a. Degenerative Changes ○ Within Normal Limits

	Severity: Disc Hght	Severity: Mild	Severity: Moderate	Severity: Severe	Disc Wedging: Ant	Disc Wedging: LL	Disc Wedging: RL	Disc Wedging: Post	Listhesis (Body Position): Ant	Listhesis (Body Position): LL	Listhesis (Body Position): RL	Listhesis (Body Position): Retro	Foraminal Encroach: Left	Foraminal Encroach: Right	Facet Asym: Left	Facet Asym: Right	Osteophyte / DJD: Ant	Osteophyte / DJD: LL	Osteophyte / DJD: RL	Osteophyte / DJD: Post	Disruption Spn-Lam		Spondylolysis: Left	Spondylolysis: Right	Spondylolisthesis Grade: 1	2	3	4	5	Spondylolisthesis Classification: I	II	III	IV	V	
L1	1/2	+	++	+++	1/2	1/2	1/2	1/2	1	1	1	1	1/2	1/2			1	1	1	1	1	L1	L	R	1	2	3	4	5	I	II	III	IV	V
L2	2/3	●	++	+++	2/3	2/3	2/3	2/3	2	2	2	2	2/3	2/3	2	2	2	2	2	2	2	L2	L	R	1	2	3	4	5	I	II	III	IV	V
L3	3/4	●	++	+++	3/4	3/4	3/4	3/4	3	3	3	3	3/4	3/4	3	3	3	3	3	3	3	L3	L	R	1	2	3	4	5	I	II	III	IV	V
L4	4/5	+	++	+++	4/5	4/5	4/5	4/5	4	4	4	4	4/5	4/5	4	4	4	4	4	4	4	L4	L	R	1	2	3	4	5	I	II	III	IV	V
L5	5/1	+	++	+++	5/1	5/1	5/1	5/1	5	5	5	5	5/1	5/1	5	5	5	5	5	5	5	L5	L	R	1	2	3	4	5	I	II	III	IV	V
S1															S1	S1																		

b. Lumbar Curve

○ Well Maintained	+ Mild
○ Hyperlordotic	● Mod
● Hypolordotic	+++ Sevr

g. Transitional Segment

○ Lumbarization of S1	○ Sacralization of L5
Spatulization of L5 Transverse Processes	○ Lt ○ Rt

3. LINES OF MENSURATION

1. Ⓐ Ⓑ Ⓒ Ⓓ
2. Ⓐ Ⓑ Ⓒ Ⓓ
3. Ⓐ Ⓑ Ⓒ Ⓓ

4. SOFT TISSUE ANOMALIES ○ None

Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ Ⓖ Ⓗ

5. OF ADDITIONAL NOTE/OBSERVATION

Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ Ⓖ Ⓗ Ⓘ Ⓙ | ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

○ Spine In Midline

c. Spinous Rotation-Regn

○ None	○ Lt	○ Rt
+ Mild	++ Mod	+++ Sevr

d. Lateral Listing-Region

○ None	○ Lt	○ Rt
+ Mild	++ Mod	+++ Sevr

e. Scoliosis

	Lt	Rt	Mild	Mod	Sevr
Primary	L	R	+	++	+++
Compens	L	R	+	++	+++
Apex Level:	1/2	2/3	3/4	4/5	

f. # Vertebrae Visualized

○ 4 ○ 5 ○ 6

○ Vertebral Bodies Normal Size/Shape

h. Spinal Compression Fractures

○ None	○ Present At Level
Wedging: ○ Anterior	○ Lt Lat ○ Rt Lat
○ Step Defect	○ Endplate Disruption
○ Zone of Impaction (Radiopaque Band)	

i. Lytic / Blastic Changes

○ None	○ Present At Level
○ Cortical	○ Localized Inc. Density
○ Moth-Eaten	○ Diffuse Inc. Density
○ Permeative	○ Ivory Vertebra

j. General Osteoporosis

○ None	+ Mild	++ Mod	+++ Sevr
○ Without Fx Defect	○ With Fx Defect		

SCANTRON EW-265573-1:14

D. FURTHER RECOMMENDATIONS

● None ○ Re-Xray in: ○ Follow-up Diagnostic Testing ○ Clinical Correlation

MRI: ○ Cerv ○ Thor ○ Lumb ○ ROHNP ○ _____ CT Scan: ○ Cerv ○ Thor ○ Lumb ○ _____

Other Ⓐ Ⓑ Ⓒ

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PLEASE MAKE NO MARKS IN THIS AREA

NO MARKS HERE